Minnesota Department of Labor and Industry
ASCPS study data request -- INSURERS and SELF-INSURERS
Revised April 30, 2020

Preface: April 30, 2020 revision

The following is the only revision in the current version of this request as compared with the February 19, 2020 version:

In the "BP data -- with PPO adj" and "BP data -- without PPO adj" tabs, the conditional formatting for data items E13 and E14 (columns N and O) is corrected. In the previous version, when an encounter sequence number was reported for item E1, the conditional formatting of items E13 and E14 would revert from red to blue only when "Y" or "N" was entered. With the correction, it reverts from red to blue when "Y", "N", or "U" is entered.

Everything else is the same between the February 19 version and this revised version of the data request.

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Instructions

This request pertains only to ambulatory surgical center (ASC) patient encounters. There is a separate request for hospital outpatient encounters.

This report format allows for reporting BY an insurance company or group, self-insured company or group, TPA, bill-reviewer, clearinghouse, or other entity ON BEHALF OF an insurance company or companies, an insurance group or groups, a self-insured company or companies, and/or a self-insured group or groups. Please contact all entities who are reporting on your behalf or for whom you are reporting to coordinate your response. We wish to have complete and nonduplicative reporting.

Three data-entry tabs are described below. In these tabs, enter data in blue- and green-highlighted cells only. The numbers in yellow-highlighted cells are computed automatically.

Copying and pasting: The three data-entry tabs extensively use formulas and conditional formats within cells. Any CUTTING and pasting in the data-entry areas will cause these to malfunction. Therefore, in filling out the data-entry tabs, PLEASE DO NOT DO ANY CUTTING AND PASTING (including drag-and-drop). COPYING AND PASTING IS OK. If you copy and paste within the same column or columns, a full paste may be used. BUT IF YOU COPY AND PASTE TO A DIFFERENT COLUMN, USE "SPECIAL PASTE" AND PASTE VALUES ONLY.   If you have questions, please contact David Berry or Brian Zaidman at DLI (contact information below).

Section 1

Complete the Payer Data Table in the Payer Data tab to determine the sample encounters for individual reporting before you proceed to Section 2. Also complete the Insurer Group Member Table in the Payer Data tab if applicable (below the Payer Data Table; scroll down to locate). An illustration of how to fill out the Payer Data tab is provided in [Insurers ASCPS Video 2.](#)

Note: This report uses the term "encounter" to refer to an instance of a service or set of services being provided to a single patient during a single visit to an ASC.   An encounter typically has one bill with multiple services.

Section 1, Step 1

Complete one line in the Payer Data Table in the Payer Data tab for each insurer, insurer group, self-insurer, or self-insured group (including yourself if applicable) with which or for which you work. For an illustrative example, watch [Insurers ASCPS Video 2](#)

· Include payers that meet this condition even if you are not reporting for them via this data submission and even if they have zero population encounters to report (see below).

· However, do not include a payer for which another entity is reporting in this survey.

· If you are an insurer group reporting for individual insurer members, you may list each member separately or simply list the group in this table. **If you list the insurer group in the Payer Data Table (as indicated by an "X" in column C), also list the individual insurer members of the group in the Insurer Group Member Table (also in the Payer Data tab).**

· If you are a self-insured group, indicate the group as the payer in the Payer Data table; do not list the self-insured group members in either the Payer Data Table or the Insurer Group Member Table.

· If you are a TPA, bill-reviewer, clearinghouse, or other entity reporting for multiple payers, list each payer separately, following the guidelines just given for insurers and self-insurers and groups.

For each payer that meets the above criteria, enter data as follows in the Payer Data Table:

Indicate the payer name in column A.

In columns B-D, indicate the type of payer.
If you indicate insurer group with an "X" in column C, list the individual insurer members of the group in the Insurer Group
Member Table (also in the Payer Data tab).

In columns E-K, indicate the relationship of you, the data-submitter, to the payer.
If you are an insurer group or self-insurer group reporting for yourself, indicate "same" with an "X" in column E.

In column L, indicate whether you are reporting for this payer via this data submission.

Section 1, Step 2

The next columns involve **"countable encounters"**. A **"countable encounter"** is one that meets ALL of the following critieria:

1. **The encounter is covered by the Minnesota workers' compensation Ambulatory Surgical Center Payment System (ASCPS).** This means that the encounter involved a Minnesota workers' compensation injury or illness and was at a Minnesota ASC.
   AND
2. **The encounter is at least partially paid.**
   AND
3. **The amount paid for the encounter is not affected by a settlement.**

   The following examples are **NOT** countable encounters:

   · The injury or illness is not covered by Minnesota workers' compensation.
   · Treatment occurs at a non-Minnesota ASC.
   · The workers' comp claim or medical treatment is fully denied.
   · Payment is reduced by a settlement.

   Except for column Z in the "Payer data" tab (see below), all encounters in this data request are limited to "countable encounters".

Using the above criteria, pull data for each payer to identify the payer's "countable encounters" that have service dates from April 1, 2019 through December 15, 2109 ("report period"). These are the payer's **"population encounters".**

Indicate in column M (in the Payer Data Table) the payer's total number of population encounters.

Indicate in column N the number of population encounters (from column M) that have any PPO (preferred-provider organization) adjustment to payment. The number without a PPO adjustment is computed automatically in column O.

   NOTE to help you identify encounters with PPO adjustments: On the 835, a PPO adjustment is indicated by a Claim Adjustment Reason Code (CARC) value of "P24" for segment CAS02, CAS05, CAS08, CAS11, CAS14, or CAS17 within loop 2110 or 2100, or by a CARC value of "96" for one of these same segments when segment LQ01 is "HE" and segment LQ02 is "N381" within loop 2110. ("N381" is a Remittance Advice Remark Code (RARC).)

Section 1, Step 3

   Sampling:

   The Department of Labor and Industry (DLI) prefers that you report (in Step 2) on all of the population encounters indicated in columns N and O in the Payer Data Table -- that is, that you

include all of these encounters in your submitted sample. However, DLI recognizes that this may be difficult for entities with large numbers of population encounters and without the necessary computer programming capacity. Therefore, DLI has devised a sampling procedure for such entities. The choice of whether to report all population encounters or just a sample is specific to the payer.

Reporting on all population encounters: If you and/or the payer elect to report on all of the payer's population encounters (columns M-O in the payer data table), rather than a sample, enter "X" for the payer in column P.

Reporting on a sample: If you and/or the payer elect to report on a sample of the payer's population encounters, rather than the total, enter "X" for the payer in column Q.

Sampling procedure: The entry of "X" in column P or Q triggers the automatic computation of **sample date windows** in columns R-W. The sample date window is specific to the payer and to encounters with and without a PPO adjustment to payment. It is a subperiod within the overall report period and is with respect to date of service. It begins with the first day of the overall report period, April 1, 2019.

The sample encounters for the payer consist of those population encounters that fall within the respective sample date window (by date of service).

If you are reporting on all population encounters for the payer ("X" in column P), the two sample date windows for the payer (for PPO and non-PPO encounters) end on December 15, 2019, the last day of the overall report period. In this instance, the sample encounters consist of all population encounters.

If you are reporting on a sample of population encounters for the payer ("X" in column Q) and the respective number of population encounters is more than 50 (columns N and O), the sample date window becomes smaller as the payer's respective number of population encounters becomes larger. (A smaller sample date window means an earlier end date.)

For payers with 50 or fewer population encounters within either the PPO or non-PPO category, the respective sample date window is the entire report period, April 1, 2019 - December 15, 2019, meaning that all respective population encounters are included in the sample.

Once you know the sample date windows for PPO and non-PPO encounters, use these date windows to pull the numbers of population encounters from each payer's database that fit within these windows. Enter in columns X and Y the numbers of population encounters whose dates of service are within the sample date window for encounters with and without PPO adjustments respectively. These are the encounters you will be reporting in Section 2. The total numbers of these encounters for all payers for whom you are reporting (within the PPO and non-PPO categories) are given in cells X12 and Y12.

Column Z: Encounters with neither payment nor full denial. Enter the number of encounters with service dates within the overall report period (Apr. 1, 2019 to Dec. 15, 2019) for which the insurer had issued neither a payment nor a full denial to the ASC as of the time of data submission to

DLI. *Note: these are outside the category of countable encounters. Do not report further for these encounters.*

For an illustrative example of how to complete Section 1, watch **Insurers ASCPS Video 2.**

If cells X12 and Y12 (total sample encounters, for all listed payers, for PPO and non-PPO encounters) are both zero, you have zero encounters to report; skip to Section 3 (transmit the data). Otherwise continue to Section 2.

Section 2: Report billing and payment data for those countable encounters selected in Section 1.

The encounters to be reported are those indicated in columns X and Y in the Payer Data Table in the Payer Data tab. These are the countable encounters that fall within the sample date windows in columns R-W in the Payer Data Table.

Enter the data for each of the encounters indicated in the Payer Data Table in column X (those with a PPO adjustment) in the tab "BP data -- with PPO adj".
Enter the data for each of the encounters indicated in the Payer Data Table in column Y (those without a PPO adjustment) in the tab "BP data -- without PPO adj".

The reason for the separate tabs for encounters with and without PPO adjustments is that a more limited set of data items is requested for the encounters with PPO adjustments. DLI is not requesting service-level (line-level) data for encounters with PPO adjustments because DLI is not assessing payment accuracy for those encounters.

Note: You may complete the tabs "BP data -- with PPO adj" and "BP data -- without PPO adj" either by data-entry or by copying and pasting a computer-generated file or by a combination of the two. If you copy and paste from a computer-generated file, first open the file into Excel and then copy and paste ***values only.***

Section 2, Step 1

Encounters with PPO adjustments -- "BP data -- with PPO adj" tab

For an illustration of how to complete this tab, watch **Insurers ASCPS Video 3.**

Report one line for each sample encounter indicated in the Payer Data Table in column X (those with a PPO adjustment), regardless of the number of services for the encounter. For example, if column X in the Payer Data Table says 10, report 10 lines of data for these 10 encounters. If a payer has zero encounters indicated in column X in the Payer Data Table, leave the "BP data -- with PPO adj" tab blank.
Data items are in columns E1-E14.
Rows 3-7 describe each data item and indicate when it is to be reported.
Row 6 is the 837/835/277 reference. Where it exists, this is the correct source of the data.
Items E1-E14 are to be completed for each encounter you report.
The encounter sequence number (item E1) will be used to identify encounters if DLI has questions. Number the reported encounters "1", "2", etc.

Item E2, the payer name, should appear exactly as in column A of the Payer Data table in the Payer Data tab.

Dispute definition: For item E14, regarding whether a dispute has been filed with DLI or the Office of Administrative Hearings (OAH), **"dispute"** means that a request for certification (medical) or medical request was filed with the DLI or a claim petition was filed with the DLI or OAH with respect to at least one of the services in the encounter.

> NOTE: The presence of a sequence number (item E1) is deemed to indicate that there is an encounter. When you add the sequence number to a line, all other data items but one for that line will be highlighted in red. These data items need to be completed for that encounter. The cells for these data items will remain red until they are filled with valid data. "Valid" means, for example, that dates are consistent with each other and that the data item complies with the description provided in Row 7. If you add a sequence number that is the same as the previous one, those two sequence numbers will be highlighted because they should be different.

Section 2, Step 2

Encounters without PPO adjustments -- "BP data -- without PPO adj" tab

For an illustration of how to complete this tab, watch **Insurers ASCPS Video 4.**

Report one line for each service for each sample encounter indicated in the Payer Data Table in column Y (those without a PPO adjustment). If a payer has zero encounters indicated in column Y in the Payer Data Table, leave the "BP data -- without PPO adj" tab blank.
Data items are in columns E1-E14, S1-S2, and S4-S8.
Rows 3-7 describe each data item and indicate when it is to be reported.
Row 6 is the 837/835/277 reference. Where it exists, this is the correct source of the data.
Items E1-E14 are to be completed for each encounter you report.
The encounter sequence number (item E1) will be used to identify encounters if DLI has questions. Number the reported encounters "1", "2", etc.
Item E2, the payer name, should appear exactly as in column A of the Payer Data Table in the Payer Data tab.

Dispute definition: For item E14, regarding whether a dispute has been filed with DLI or the Office of Administrative Hearings (OAH), **"dispute"** means that a request for certification (medical) or medical request was filed with the DLI or a claim petition was filed with the DLI or OAH with respect to at least one of the services in the encounter.

Items S1-S2 and S4-S8 are to be completed for each reported service for each encounter you report.
If an encounter has just one service needing to be reported , continue in the same row to complete items S1-S2 and S4-S8.

If an encounter has more than one service needing to be reported, you will need to use multiple lines for that encounter to accommodate all the reported services. To do this, follow

these steps:

1. Enter an encounter sequence number (item E1) to as many lines as there are reportable services for the encounter. The encounter sequence number should be the same for all lines for the same encounter.
2. Complete items E2-E14 in the first line for the encounter.
3. Complete items S1-S2 and S4-S8 for each reported service (line) for the encounter.

For an illustration of do this , watch **Insurers ASCPS Video 4.**

NOTE: The presence of a sequence number (item E1) that is different from the prior one is deemed to indicate that there is a new encounter. When you add a sequence number to a line that is difference from the prior number, all other data items but one for that line will be highlighted in red. These data items need to be completed for that line. The cells for these data items will remain red until they are filled with valid data. "Valid" means, for example, that dates are consistent with each other and that the data item complies with the description provided in Row 7. If the sequence number you add is the same as the previous one (indicating an additional service for the same encounter), only service-level data columns will be highlighted; this is because you only need to complete the encounter-level data for the first line for the encounter.

Section 3: Submit the data file

Do this even if you had no individual encounters to report in Section 2. DLI still needs the information you entered in the Payer Data tab.

The due date for the data is July 31, 2020.

Submit the data via upload at the following secure website:
https://secure.doli.state.mn.us/dlidata20/ Further instructions are on that website.
It does not matter what you name your file. DLI will identify your file with the information you supply on the data submission website.

Questions?

Contact David Berry, david.berry@state.mn.us, 651-284-5208 or Brian Zaidman, brian.zaidman@state.mn.us, 651-284-5568.